Department of Veterans Affairs

Prevention Notes

From the Director's Desk

National Conference on Health Promotion

The reorganization of VHA operations creates new opportunities to bring the right service, in the right place, at the right time to enrolled veterans in order to maximize health. To envision our opportunities and prospects, experts in health promotion and disease prevention met at Airlie Center in November 1998. The deliberations provided the NCHP with an overview of coming attractions suitable for application in the VA. Here is a description of some main themes.

Having a superb health program is not sufficient to assure success in motivating enrollees to achieve their maximum potential. The health care system must constantly adapt to the wants and needs of consumers. The enrollee must find the prospect of behavior change compelling. "Social Marketing" strategies that sell services fitted to enrollee needs will make the difference between a modest and an enthusiastic participation rate.

The tailoring of services begins with a health risk appraisal at enrollment. We use that assessment to create specific strategies that address enrollee health needs. The goal is that every enrolled veteran receives personalized information, encouragement and support to improve self-care.

At enrollment, every veteran should receive a booklet with information about health and medical care. Booklet distribution is widely used in managed care to teach basic information on a host of health related topics. Having a booklet referenced during a VA telephone contact or a clinic visit further enhances self-care. Where booklets are distributed, enrollees assume added responsibility for personal wellness thus reducing the demand on the health system.

Experts link disease burden with a handful of personal health behaviors.[1] Although screening and immunization are invaluable for disease prevention and control, it is through changes in personal health behavior that the greatest opportunity exists to maximize health potential. The United States Preventive Services Task Force (USPSTF) found all the leading causes of death can be reduced by changing personal behaviors such as smoking, intoxication, physical inactivity, improper diet, and failure to use safety devices.[2] Behavior change strategies present a major opportunity to improve the health of veterans.

A personal annual review of each enrollee's program opens opportunities to emphasize strategies for continued good health. Since enrollee motivation and commitment fluctuate, periodic reassessment and modification are essential. The goal is a partnership to build enrollee skills for behavior change.

Forward-looking care systems make services available in the community where enrollees live through innovative links with local agencies and resources that enhance access. The challenge is to maintain a seamless continuum between health promotion, primary care and specialty services with programs at different sites and agencies. New information system technology offers hope this problem can be resolved.

The achievement of maximum health requires a significant time commitment to help each enrollee advance a personal care plan. The complexity of current health promotion strategies, coupled with the demands of clinical practice, have led clinicians to assume a role as "change agent" with many health services being offered through a team. Team training and optimal deployment strategies remain an area of intense interest and development.

The VA should promote its image of providing excellent clinical care linked with knowledge advancement through affiliations with distinguished academic institutions. Enrollee interest in participation grows substantially when the quality of the health care organization is fully appreciated.

It was surprising how many strategies considered visionary by some conference participants are already being used in the VA. Many elements of the future are with us already but are unevenly distributed. The purpose of this meeting was to delineate those with special value. The NCHP will incorporate them into a strategic plan to help every veteran achieve the maximum health potential.

Robert J. Sullivan Jr., MD, MPH
Director, National Center for Health Promotion and Disease Prevention

[1] McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993;270:2207-2212.

[2] U.S. Preventive Services Task Force. Guide to clinical preventive services, 2nd ed. Baltimore: Williams & Wilkins. 1996.

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Winter 1999 Vol. 3 #4

National Center For NCHP HEALTH PROMOTION

Editor's Notes

Summary PMPC Conference Call October 6, 1998

93 (57%) interested Preventive Medicine Program Coordinators and other health promotion/disease prevention staff phoned in for the first call of FY 1999. The conference calls are held twice yearly and are the major means of bringing the field up-to-date on National Center for Health Promotion activities. The other means are the quarterly newsletter, our home page and the annual national training program. We encourage you to attend to as many of these venues of communication as you can. Our last phone call in March yielded a phone-in attendance of 112 or (68%).

Dr. Ellen Yee, Preventive Medicine Field Advisory Committee member moderated the call substituting for Lois Katz, Chair of the Committee. Dr. Yee is Co-director of the Womens Clinic in Sepulveda. Dr. David R. Reagan, new PMFAG member and Director, Primary Care at Johnson City, TN VAMC was introduced *(see p. 7).*

Third Annual Prevention Meeting

Dorothy Gagnier, Assistant Director, Education NCHP reported on the national prevention meeting held September 15 – 17 in New Orleans. 230 VA health care professionals interested in promoting the health status of veterans attended the conference. The meeting differed from previously held ones in the travel funding mechanism and the number of non-VA presenters as faculty. The meeting was targeted toward Preventive Medicine Program Coordinators (PMPCs), Patient Health Education Coordinators (PHECs), Quality Management Officers, Network Clinical Managers and Network Preventive Medicine Coordinators (PMNCs). The goal of the meeting was to enable staff to comply with VA national prevention standards and educate, motivate, and assist facilities and networks in the development of effective prevention delivery models of care *(see "Conference Highlights" pp. 4-5).*

Ideas for Future Programs

Rose Mary Pries, PMFAG member and National Patient Health Education Coordinator, asked for comments from the field concerning both content and format for future meetings in preventive medicine. Changes in funding for both meeting attendees and faculty by the Employee Education System (EES) have made the networks and facilities key players in educational planning and participation. We are currently seeking suggestions for the best methods to package education to the field in the future *(see announcement p. 8).*

PMFAG Meeting Held

The Preventive Medicine Field Advisory Group, consulting body to the Primary/Ambulatory Care Office, convened on September 28-9 in Washington, DC. Dr. Ron Gebhart, Chief Consultant, Primary/Ambulatory Care, reported on Headquarters activities over the past year and began by summarizing the role and function of the PMFAG. Nine individuals working in the field are appointed for three year terms.

Also discussed was the VA's desire to serve all seven categories of veterans and the manpower implications this will have. Primary/Ambulatory care in the VA has gone from 10% to 80% enrollment. Complementary/alternative medicine in the VA is being surveyed by Dr. Gebhart's office and practices examined in terms of their evident value. More information will be forthcoming *(see **Prevention Notes**, Summer 1998, Vol. 3 #2)*. A VA Clinical Guidelines committee is investigating existing guidelines to determine which ones are most appropriate for the VA and can be adapted to an easy-to-use format. The guidelines initiative is now being done in collaboration with the Department of Defense (DOD) who is very interested in using VHA guidelines. An increased relationship with the Department of Defense is being explored, particularly with their Tri-Care program. The Health Evaluation and Assessment Review (HEAR), a military requirement for all enrollees which offers information about health habits, is a possible area for cooperation. Billing for services in the VA may be expected in the future as well.

Among the projects worked on by the advisory group throughout the year were pharmacologic therapy for nicotine replacement therapy, mammography issues, and tobacco cessation. National Center activities over the past year were also reported. Dr. Anne Joseph, PMFAG member spoke briefly about the release of tobacco documents at the conclusion of the Minnesota law suit. It seems the tobacco companies knew years ago of the value of handing out cigarettes to military enlistees. This information could have some implications concerning VA liability for tobacco-related diseases.

The meeting provided an opportunity for committee members to review projects of the past year and make plans for the future.

NCHP Handbook Revision

The new *Handbook* will replace the current *1101.8* edition published in 1996. It incorporates most of the prevention recommendations from VA Handbooks, Guidelines and the Prevention and Chronic Disease Indexes. Immunizations and screening information has been supplemented with information from these other sources. A table at the front of the publication tells the origin of each recommended practice. Citations are also given for easy reference to original documentation. Since new data sources are now available the annual report requirement from the field has been eliminated. The new *Handbook* is now in the final phases of concurrence in Headquarters.

Prevention Coding

In concert with the Handbook, documenting of prevention services remains a primary concern. Current CPT and ICD codes do not cover prevention. The Center has developed a new coding proposal and submitted it to the Information Technology Clearinghouse in August. The new coding system will capture every item in the latest Handbook. The new codes should make the reminder system work better.

Veteran's Health Survey Update

The 1998 Survey results were mailed to the field in August: to the Medical Director, the Associate Chief of Staff, ACOS Primary/Ambulatory Care, the JCAHO Coordinator, and the PMPC and PHEC at each facility. If you did not receive a copy contact David Brown, Survey Coordinator and he will be happy to send you one. The 1998 Survey had an adjusted response rate of 67%. The 1999 Survey was mailed on December 1.

PMPC Conference Call

The next PMPC conference call will be held **March 2, 1999** at **1:00 – 1:50pm EST; 12:00 – 12:50 pm CST; 11:00 – 11:50 am MST; 10:00 – 10:50 am PST;** and **9:00 – 9:50 am AST**. The call in number is **1.800.767.1750**. Anyone working or interested in prevention is invited to join the call.

Dorothy R. Gagnier

Newsletter Editor
Dorothy R. Gagnier, Ph.D.
Assistant Director, Education
National Center for Health Promotion and Disease Prevention

Implementing Prevention Practices: The Way Forward

A shift is currently underway in the Veterans Health Administration (VHA) to a health care delivery model called "VA CARE," a program aimed at maximizing each veteran's health potential. In the emerging VA culture, health promotion and disease prevention is becoming more prominent and requires new methods of operation and practice. This article presents two network models which actively coordinate dissemination and implementation in order to ensure that preventive medicine recommendations are implemented.

Changing clinical practice patterns is challenging. A recent review of interventions that promote professional behavior change and improve patient outcomes was conducted by over 100 researchers in 12 countries on behalf of the Cochrane Effective Practice Review Group (Bero, et al., BMJ 1998; 317:465-8). Interventions categorized as *consistently effective* included interactive education, reminders, multifaceted interventions (2 or more of the following: audit and feedback, reminders, local consensus processes, or marketing), and educational outreach. The overview indicated that passive dissemination of information alone is ineffective, no matter how important the issue. The authors plan to publish an update of this overview in early 1999. In general, the evidence supports combinations of interventions that address several perceived barriers to behavioral change among professionals. Multifaceted interventions in VHA to integrate prevention into daily practice patterns currently include disseminating recommendations and guidelines, audit and feedback, reminders, and performance measures.

VHA staff are increasingly faced with volumes of information, priorities and requests for action. Leaders at all levels must develop expertise in the principles of managing change and accept the need for coordinating competing priorities thus enabling clinicians to deliver the best care possible. Comments from the field indicate the need for close communication between network leaders and front line staff for implementing prevention. As networks move to an integrated managed care system, they are faced with the task of effectively managing the change process to reframe care delivery while at the same time maximizing available resources and meeting performance contracts. Accordingly, VISNs vary in their approaches to systematically meet these challenges.

The following is the VISN 16 approach: multi-facility activities were set up to address health promotion initiatives. The Primary Care Advisory Committee (PCAC), originally chartered in 1997, serves as a major strategic planning group. To obtain organizational buy-in and stimulate thinking beyond traditional frameworks, the PCAC is multidisciplinary with both clinical and administrative representatives. The committee develops tactics to incorporate targeted prevention practices into patient care.

Preventive medicine measures were placed in the Chiefs of Staff performance contracts. This reinforced organizational commitment to preventive medicine activities. Many of the Chiefs of Staff have utilized the Preventive Medicine Program Coordinator (PMPC) to help implement performance measures. As cultural change occurs in this process, shared responsibility has developed and with it a growing incorporation of prevention into the care provided.

In addition, both at the network and facility level, "champions" for each performance measure were established. The "champion" identifies solutions for problems encountered with data collection and other issues thereby helping sites meet their performance measures. They disseminate monthly facility performance and best practice information, sharing their findings with national and local staff. Initially the network Clinical Manager held monthly PMPC conference calls. While the PMPCs appreciated this contact, competing priorities and the committee strategic planning structure adopted by VISN 16 interfered with the call schedule and coordination of preventive medicine initiatives. The PCAC plans to explore ways to better incorporate PMPCs in network initiatives.

Network 9 is using a different approach. Together, the Preventive Medicine Network Coordinator (PMNC) and the network Clinical Manager created a 5-part plan to implement prevention activities. To begin, they have identified areas where collaboration between facilities is likely to benefit all. For example, network-wide consistent encounter forms are planned to optimize efficiency of data capture. Another target area for collaboration is sharing programming expertise between VISN 9 facilities to fully implement the PCE clinical reminders.

A working group of representatives from each VISN 9 facility will be established to address the areas where improvement is possible. While the facilitator should be connected with preventive medicine, the members of the work group who have a variety of necessary skills may not have had substantial previous involvement in prevention. It is thought that given a limited work scope the group may only need a few months to complete their tasks. Additionally, the plan calls for involving PMPCs in disseminating the results of the work group and providing answers to problems thereby enhancing the positive aspects of the PMPC role rather than just delivering practice and documentation requirements.

The network 9 plan also calls for a re-evaluation of current PMPC assignments for each facility. Discussion with PMPCs could include the status of implementation of preventive medicine guidelines, major challenges and obstacles encountered, and whether the assigned PMPC has an interest in advancing prevention activities. Appropriate reassignments could be based more on interest and expertise than job title. According to preliminary plans, PMPCs will join with primary care leaders to establish a common network wide group to facilitate delivery of primary care and preventive medicine. Collaboration will include a regularly scheduled conference call, and will aim to enhance informal communications across the network. This arrangement will attempt to minimize the additional conference calls and other administrative duties associated with organizing both primary care and preventive medicine across the network, while providing the benefits of collaboration.

Clearly, there are no magic bullets for implementing evidence-based prevention practices. The way forward requires directing attention to the match between the evidence of effectiveness of the change strategies and the characteristics of the target setting. The message itself, existing barriers, and preparedness of clinicians to change are significant factors. The NCHP stands ready to assist in this endeavor wherever such support is helpful.

Dr. Susan Pendergrass , DrPH, Clinical Manager, VISN 16 and Dr. David Reagan, MD, member of the Preventive Medicine Field Advisory Group and ACOS/PC for Mountain Home VAMC contributed substantially to this article.

Mary Burdick

Mary B. Burdick, Ph.D., RN, CS
Assistant Director, Facility Liaison
National Center for Health Promotion and Disease Prevention

Integrating Prevention and Education 1998

Third Annual Conference on Preventive Medicine in the VHA

Dr. Ron Gebhart cited VHA changes that have created larger roles for those working in prevention and education. The national conferences held the last three years are vital in bringing together these two groups of professionals for networking and sharing ideas.

Dr. Rob Sullivan, Director, National Center for Health Promotion and Disease Prevention (NCHP) discussed the revised NCHP handbook which is now in concurrence for approval at Headquarters. The Guide contains a useful chart which compares VA Guidelines with the Chronic Disease and Prevention Indices. Draft copies of the document were distributed to attendees. Dr. Sullivan also spoke about the proposed prevention code system also currently being reviewed in Headquarters.

Renee Donaldson, Clinical Manager for the Upper Midwest VISN (Network 13), Minneapolis encouraged audience members to remain vigilant as VHA changes are instituted, reminding them that through critical analysis progress is made.

Dr. Jacqueline Pugh, Director of the Veterans Evidence-Based Research Dissemination Implementation Center (VERDICT), San Antonio, illustrated the evidence-based prevention approach using exercise and prostate cancer screening as examples.

The case for and against hormone replacement therapy was delivered by Dr. Ellen Yee, followed by a discussion of the advantages and disadvantages of prostate cancer screening by Dr. Rodney Davis, Chief Urology Section, New Orleans VAMC and Kurt Link, MD, Chief Primary Care Service at the Richmond VAMC.

Dr. John Demakis, Director, Health Services Research and Development Services (HSR&D), Headquarters, described prevention research opportunities in the VA. Present initiatives include telemedicine, cost containment centers, nicotine tobacco research centers and a newly funded program, QUERI (Quality Enhancement Research Initiative) whose goal is to apply research to clinical care.

Several prominent non-VA professionals rounded out the faculty roster. One of the most notable was David Atkins, MD, MPH, Agency for Health Care Policy and Research (AHCPR), Center for Practice and Technology Assessment, who summarized the Heatlhy People 2010 Initiative. He believes the VA has positioned itself to assume a leadership role in prevention along with some of the other larger staff model HMOs. The VA's structure makes it easier to implement change because of its centralized data system.

Ashley Coffield, MPA, Vice-President, Partners in Prevention in Washington, DC spoke about prioritizing care based on cost analysis. Kate Lorig, a national leader in patient education advised about applying good principles of patient education to prevention. Adele Franks, Associate Director, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention (CDC) discussed the Surgeon General's Report on Physical Fitness (1996); and Dr. Ned Calonge, Chief of Preventive Medicine and Research for Kaiser Permanente in Denver, presented an overview of prevention and managed care in the private sector.

Concurrent sessions included a systems approach to practicing prevention presented by Pat Henfling, Richmond VAMC and Richard Harvey of the Charleston VAMC; prevention for older veterans by Cathy Alessi, Director of the Geriatric Evaluation Service, Sepulveda; effective communication skills, Pam Hebert, Employee Education System, Birmingham; prevention in private sector managed care, M.A. Krousel-Wood, Director of the Preventive Medicine Residency Program, Tulane University Medical School; smoking cessation presented by Linda Ferry, Chief Preventive Medicine, Loma Linda VAMC; prevention program community outreach, Kevin Wintergerst, Louisville VAMC; and the HEAR (Health Evaluation Assessment Review) Project by Major Dixie Lyon, DOD, Air Force Office for Prevention and Health Service Assessment. An update on the NCHP Veterans Health Survey took place on the last day of the meeting.

In his concluding remarks, Dr. Gebhart charged meeting participants to continue to work together through their networks so that real progress in prevention can be realized.

(Left) Dr. Ron Gebhart, Chief Consultant, Primary/ Ambulatory Care, Headquarters explains a point to the audience at the third annual training program in prevention.

(Left) David Atkins, Center for Practice and Technology Assessment, Agency for Health Care Policy and Research (AHCPR) talks about Healthy People 2010.

(Left) Adele Franks, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention (CDC) responds to questions concerning the Surgeon General's Report on Physical Activity which she edited.

(Right) Dr.. Rob Sullivan, Director, NCHP presents an update on the new NCHP Handbook.

(Right) Renee Donaldson, Clinical Manager, VISN 13 Minneapolis, discusses networking in the VISN.

(Right) Rose Mary Pries, Employee Education System, St. Louis, greets meeting participants at the opening session.

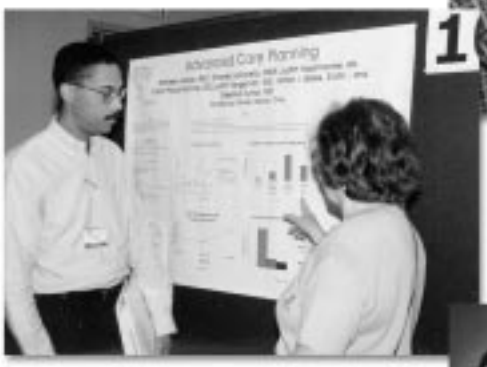
Posters on Prevention

(Left) Staff Sargeant Ed Correa and Major Dixie Lyon, Office for Prevention and Health Services Assessment, United States Air Force, demonstrate Project HEAR.

(Right)Josephine C. Malone, VAMC, Grand Junction, Co displays "Eating Smart" project.

(Left) Lynne Koerner, and Deborah Kupecz, VA OPC at Fitzsimmons, Aurora, CO illustrate the success of various smoking cessation treatments to Ellen Yee, Sepulveda VAMC and PMFAG member.

(Right) Charlene L. Stokamer, VAMC New York, NY discusses a successful health fair with Rose Mary Pries, PMFAG member and a conference attendee.



(Left) Judith Nassmacher, VAMC Dayton, OH highlights findings from a study on advanced care planning.

(Right) Wallon Hamilton and Paul West, Sepulveda VAMC present information on implementing clinical practice guidelines to Julie Dolan with the Veterans Health Services Journal.

Pearls for Preventive Care
Georgia Daniel, CFN
Clarksburg, VA VAMC

Fecal Occult Blood Testing
Nomie G. Finn, MD, FACP
Sue Jones, RN
Big Spring, TX VAMC

Women's Health Clinic: Education & Practice
Rebecca Gump, RN, MSN, ANP
Northern Indiana Health Care System
Fort Wayne, IN

Effect of a Health Education Program on Ambulatory Veterans
Pat Henfling, RN, MEd
Richmond, VA VAMC

Individualized/Customized Exercise Prescription for Weight Loss
Jean Higashida, MD
Marilyn Kerkhoff, RNP

Campaign of Awareness
Ann Kelly, RN
San Diego, CA VAMC

Alternative Patient Education Interventions To Promote Health Behaviors
Karen M. Kolbusz, MBA, RN
Hines, IL VAMC

Comparison of Smoking Cessation Treatments
Lynne Koerner, NP
Deborah Kupecz, NP

Eating Smart
Josephine C. Malone, RD
Grand Junction, CO VAMC

Advanced Care Planning
Judith Nassmacher, RN
Dayton, OH VAMC

Smoking Cessation Program
Frederick Peterson, PsyD
Judith Nassmacher, RN

Depression Screening in Primary Care
Jerry Strauss, PhD
Scott K. Ober, MD, MBA

Implementing Clinical Practice Guidelines in a Network Of Outpatient Clinics
Scott E. Sherman, MD, MPH
Mark Graham, MA

Passport to Health Education – A Health Fair With a Difference
Charlene L. Stokamer, MPH, RN, CHES

Veterans Health Survey Update

Who are the stars in providing health promotion services in the VA? The 1998 Veterans Health Survey (VHS) provides an opportunity to examine this question. In the last issue of *Prevention Notes*, we looked at the absolute performance of the combined 148 primary care sites by areas of preventive care. Now we are examining the consistency of these 148 sites in the provision of these services. What are the prevention areas in which we are all doing about the same? What are the areas where some are doing better than others? First, we can identify those areas in which the system as a whole is most widely divergent in its level of service. Next, we can examine the nature of the divergences for clues to this pattern. After such an analysis, we can identify those high performing sites in each area whose methods may be of special assistance to others in fulfilling their service mission.

The chart below illustrates this approach. For the purposes of this ranking, those sites with the lowest and highest 5% performance have been excluded, and the health promotion services ranked by the resulting spread. From this perspective, a number of areas appear worthy of further investigation which could result in methods for improving overall system performance.

For example, note the figures regarding the provision of the Tetanus/ Diptheria booster to both male and female veterans at least once in the past decade. In both these areas system performance is widely divergent, at 28% and 29% respectively. Considering all 148 sites, the top 5 sites achieved rates of 67% to 74% for men and 77% to 82% for women in this area versus a mean of about 53% for men and 60% for women overall. Here it appears that men and women are receiving the service at a similar rate. Given the overall divergence though, the top performing sites for both sexes could profitably offer suggestions to other sites to minimize the divergence.

There are also those service areas which show marked differences between the size of spread in male and female services. The most obvious example in this initial ranking is for the provision of influenza vaccine. While the spread for men is 17%, the spread for women is considerably larger at 33%. Again considering all 148 sites from the 1998 VHS, the top 5 sites for men achieved rates of 87% to 95% versus a mean of about 75% for the system. The top four sites for women achieved rates of 91% to 100% versus a mean of about 69% for the system. The good news is that the system is capable of high success rates for both men and women in this area. The other news is that, despite very great success for women veterans in some locations, other sites are experiencing genuine difficulties in providing this service to this segment of the veteran population and may especially profit from the specific experiences of sites which have had success in providing this service to women.

These are some examples of how this type of analysis of the Veterans Health Survey can assist in serving veterans better. We welcome your comments as we continue to examine future possibilities for use of this data.

David Brown, NCHP Research Assistant prepared this report.

Health Promotion and Disease Prevention Services

	Spread of the middle 90% of sites	Low % (>5%)	High % (<95%)
Pneumococcal Vaccine at least once for Females age 65 and over	36	50	86
Fecal Occult Blood in past year or Sigmoidoscopy in past 5 years for Females	34	33	67
Influenza Vaccine in the past year for Females age 65 and over	33	55	88
Td Booster at least once in the past decade for Females	29	45	74
Pneumococcal Vaccine at least once for Males age 65 and over	28	54	82
Td Booster at least once in the past decade for Males	28	37	65
Tobacco Counseling in the past year for Females	26	68	94
Mammogram in the past 2 years for Females age 50 to 69	25	71	96
Fecal Occult Blood in past year or Sigmoidoscopy in past 5 years for Males	23	44	67
Activity Counseling in the past year for Females	23	48	71
Accident Avoidance Counseling in the past year for Females	23	7	30
Cholesterol Check in the past 5 years for Females age 45-65	22	73	95
Alcohol Use Screening in the past year for Females	19	20	39
Nutrition Counseling in the past year for Females	19	40	59
Cholesterol Check in the past 5 years for Males age 35-65	18	72	90
Tobacco Counseling in the past year for Males	18	70	88
Influenza Vaccine in the past year for Males age 65 and over	17	67	84
Alcohol Use Screening in the past year for Males	16	31	47
Nutrition Counseling in the past year for Males	16	44	60
Activity Counseling in the past year for Males	16	52	68
Accident Avoidance Counseling in the past year for Males	16	9	25
Pap Test in the past 3 years for Females under age 65	13	81	94
Blood Pressure Check in the past 2 years for Females	10	81	91
Blood Pressure Check in the past 2 years for Males	7	84	91

Q&A

Q. Is the VA considering using the DOD HEAR (Health Evaluation and Assessment Review) program?

A. Some networks are examining the program with a view toward implementation. For example, it is currently under consideration in VISN 6. The instrument collects information on prevention at time of enrollment beneficial for health care planning at the network, facility and individual levels.

Q. Who will receive the revised NCHP Handbook?

A. The *Handbook* due out soon, will be distributed widely within the VHA. It will be distributed to: Preventive Medicine Program Coordinators (PMPCs); the Patient Health Education Coordinators (PHECs), and leadership in Primary/Ambulatory Care. Medical facility libraries will also receive copies.

Q. Are VHA prevention measures tested before promulgated to the field?

A. All of our recommendations are evidence-based. Many of the recommended practices are already being accomplished in VA medical facilities through the practice of good medicine. Sometimes political concerns pressure recommending practices, i.e. PSA counseling, frequency of mammography screening, etc. At present, the NCHP is working with the CDC to rank order prevention measures in terms of cost value.

Q. Will the new Handbook incorporate Healthy People 2010 goals?

A. Healthy People 2010 goals have been removed from the *Handbook*. We believe that the VHA can accomplish more than the standards set by these measures. Our aim is to surpass the best managed care systems operative in the country today.

Q. Are any of the items distributed at the recent meeting in New Orleans available? How can I go about obtaining them?

A. There are a limited number of binders left over from the prevention meeting in September. Rose Mary Pries informs that if you contact her she can handle your request and possibly print up sections of the handouts that were dispersed at the meeting.

Q. How can Veterans Health Survey data be used for JCAHO review?

A. The Joint Commission requires a survey for documenting enrollees satisfaction with services. Since the Veterans Health Survey deals with receipt of services by veterans both within and outside of the VA, it addresses one or more of the questions raised by the Commission. Where feedback from veterans is requested, information from the Veterans Health Survey has proved useful.

NB: If you have utilized VHS data in this regard, please let Mary Burdick or Dorothy Gagnier know.

Q. Where are the VA Guidelines for Clinical Care located?

A. The Guidelines are found on the VA home page at <www.va.gov>. Select the word Medical and scroll down to Clinical Practice Guidelines. You can download a copy of these Guidelines onto your computer.

Q. Are the Guidelines to revaccination against* Streptcoccus Pneumoniae *published?

A. The guidelines or specific indications for revaccination against Streptococcus Pneumoniae are published in the CDC publication, *Morbidity and Mortality Weekly Report*, April 4, 1997: Vol. 46, No. RR-8, pages 1-24.

Q. Is there new information related to the prevention of Hepatitis C virus infection?

A. A recent conference convened by the Centers for Disease Control and Prevention presented new findings. These can be found in the *Morbidity and Mortality Weekly Report*, October 16, 1998: Vol.47, No. RR-19. (See *Prevention Notes*, Fall, 1998, Vol.3 #3 for other issues related to Hepatitis C).

PMFAG Welcomes David Reagan

David R. Reagan, MD, Ph.D., is the newest member of the Preventive Medicine Field Advisory Group. Dr. Reagan is Director of Primary Care at the Mountain Home VAMC. He received his academic training at Vanderbilt University and completed residency training in Internal Medicine in Clinical Epidemiology and Infectious Diseases at the University of Iowa. His research interests include application of molecular biologic techniques to hospital epidemiology and the epidemiology of infections by methicillin resistant *Staphylococcus aureus.* Previously, Dr. Reagan was Chief of Infectious Diseases at the Mountain Home VAMC. He assumed Primary Care Directorship in 1995. He is the Preventive Medicine Coordinator for Network 9.

The Future Is Now

November 9-10, 1998

The National Center for Health Promotion sponsored a retreat at Airlee House in Warrenton, Virginia to envision opportunities and prospects for prevention in the VA. National experts in health promotion joined VHA leaders in considering an ideal health care system for 2005 that assures enrollees maximization of their health potential. Participants concluded that future services must be enrollee-centered, emphasize behavior change and be community-based. Some of the visionary strategies considered by meeting consultants are already at work in the VHA. One of the goals as a result of the meeting will be to standardize these practices. A strategic plan embracing these concepts and drafted by NCHP staff has gone forward to Headquarters for approval.

Participants gathered for a group photo before adjourning.

First Row L to R: Ron Gebhart, Ruth Carpenter, Mary Burdick, Mary Wakefield, Nancy Garfield, Susan Horn

Second Row L to R: Rob Sullivan, Mildred Eichinger, Don Vickery, Tom Kottke, Dorothy Gagnier, Bob Lawrence

Third Row L to R: Don Kemper, Verona Hegarty, Harvey Estes

Fourth Row L to R: Steve Jonas, Gregg Pane, Jack Feussner, David Sack

Fifth Row L to R: Jeff Harris, Bob Wallace, David Atkins, Larry Chapman, Larry Branch

Education Meeting Announcement

PMFAG member Rose Mary Pries has requested input regarding formats for future educational programs. As the possibility of national programs becomes less desirable, Ms. Pries asks that staff working in prevention send us ideas concerning alternative teaching/learning formats, i.e., satellite video conferences, regional programs, computer-assisted programs, etc. Send them to Ms. Pries at the St. Louis Education Center: Phone **314.894.5742** Fax **314.894.6550** or Dorothy Gagnier at the National Center for Health Promotion: Phone **919.416.5880 Ext. 226** or Fax **919.416.5879**. We are pleased with the enthusiastic response to our educational programs over the past three years and hope that this same momentum can continue but perhaps in different venues.

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Address Correction Requested

Putting Prevention Into Practice in the VA